United States Department of Labor
Employees' Compensation Appeals Board

J.M., Appellant	)	
and	)	**Docket No. 08-1706**
	)	**Issued: December 24, 2008**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Muskogee, OK, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 2, 2008 appellant filed a timely appeal from an April 1, 2008 decision of the Office of Workers' Compensation Programs adjudicating her claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than 15 percent impairment of her right lower extremity.

FACTUAL HISTORY

On May 18, 2005 appellant, then a 53-year-old part-time physician, sustained a work-related lumbar spine sprain and strain and right hip contusion when she slipped on a wet floor and fell. The Office subsequently upgraded her claim to include a sprain and strain of the right

hip and thigh and sacroiliac area of the spine, a right knee strain and left hip strain. On September 12, 2006 appellant filed a claim for a schedule award.

In an August 16, 2006 report, Dr. Kenneth R. Trinidad, an attending Board-certified internist, provided findings on physical examination. He found that appellant had 59 percent impairment of the right hip, including 7 percent for trochanteric bursitis, according to Table 17-33 at page 546 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (the A.M.A., *Guides*), 5 percent for loss of range of motion based on 80 degrees of flexion, 15 degrees of extension, 20 degrees of internal rotation, 25 degrees of external rotation, 20 degrees of abduction and 15 degrees of adduction, and 47 percent for Grade 4/5/ weakness in flexion, extension and abduction, according to the ankylosis tables at page 539 in section 17.2g (Joint Ankylosis). Dr. Trinidad found that appellant had 24 percent impairment of the whole person based on her right hip condition.

On October 31, 2007 the Office referred appellant to Dr. Srikanth K. Reddy, a Board-certified physiatrist, for an examination and impairment rating of her right lower extremity. In a November 8, 2007 report, Dr. Reddy provided findings on physical examination. She determined that appellant had 15 percent impairment of her right hip, including 5 percent for 20 degrees of internal rotation, 5 percent for 20 degrees of external rotation, and 5 percent for 20 degrees of abduction. Dr. Reddy found no impairment based on 105 degrees of flexion, 20 degrees of extension and 20 degrees of adduction. She indicated that appellant had uncomfortable and sometimes distressing hip pain but she did not respond to a "[h]ip" impairment form question as to whether there was sensory loss in appellant's hip. On an impairment form for the "[l]ower [e]xtremity," Dr. Reddy indicated that appellant had moderate to severe pain but checked "[n]o" in answer to the question as to whether there was neurological involvement.

On December 12, 2007 Dr. H. Mobley, an Office medical adviser,[1] stated that appellant had 15 percent impairment of the right lower extremity for loss of range of motion based on Dr. Reddy's report and Table 17-9 at page 537 (Hip Motion Impairment) of the A.M.A., *Guides*. This included five percent for 20 degrees of internal rotation, five percent for 20 degrees of external rotation, and five percent for 20 degrees of abduction. Dr. Mobley indicated that there was no impairment for 105 degrees of flexion, 20 degrees of extension and 15 degrees of adduction.[2]

[1] *See* Federal (FECA) Procedural Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.6(d) (August 2002) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

[2] Dr. Mobley erred in stating that adduction was 15 degrees. Dr. Reddy found 20 degrees of adduction.

By decision dated April 1, 2008, the Office granted appellant a schedule award based on 15 percent impairment of her right lower extremity for 43.2 weeks,[3] from November 2, 2007 to August 30, 2008.[4]

LEGAL PRECEDENT

Section 8107 of the Act[5] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*.[6]

The A.M.A., *Guides* provides for three separate methods for calculating the lower extremity permanent impairment of an individual: anatomic, functional and diagnosis based.[7] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[8] The diagnosis based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[9] The functional method is used for conditions when anatomic changes are difficult to categorize, or when functional implications have been documented, and includes range of motion, gait derangement and muscle strength.[10] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[11] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[12] If more than

[3] The Federal Employees' Compensation Act provides for 288 weeks of compensation for 100 percent loss or loss of use of a lower extremity. 5 U.S.C. § 8107(c)(2). Multiplying 288 weeks by 15 percent equals 43.2 weeks of compensation.

[4] Subsequent to the April 1, 2008 Office decision, additional evidence was associated with the file. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal. The Board notes that the Office has not issued a final decision on appellant's claim for a schedule award for her left lower extremity and right upper extremity.

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404 (1999). Effective February 1, 2001, the Office began using the A.M.A., *Guides* (5th ed. 2001).

[7] A.M.A., *Guides* 525.

[8] *Id.*

[9] *Id.*

[10] *Id*. at 525, Table 17-1.

[11] *Id*. at 548, 555.

[12] *Id.* at 526.

one method can be used, the method that provides the higher impairment rating should be adopted.[13]

ANALYSIS

Dr. Trinidad found that appellant had 59 percent impairment of the right hip, including 7 percent for trochanteric bursitis, according to Table 17-33 at page 546 in section 17.2j (diagnosis-based estimates) of the A.M.A., *Guides*, 5 percent for loss of range of motion based on 80 degrees of flexion, 15 degrees of extension, 20 degrees of internal rotation, 25 degrees of external rotation, 20 degrees of abduction and 15 degrees of adduction, and 47 percent based on joint ankylosis. There are three deficiencies in this report. Table 17-2 at page 526, the cross-usage chart, does not allow for lower extremity impairment to be based on a combination of range of motion or ankylosis deficits and a diagnosis-based estimate. Dr. Trinidad found five percent impairment based on decreased range of motion but Table 17-9 at page 537 provides for five percent impairment for each of appellant's six hip range of motion measurements. He found that appellant had 24 percent impairment of the whole person based on her right hip condition. However, whole person impairment is not permitted under the Act.[14] Due to these deficiencies, Dr. Trinidad's report is not sufficient to establish appellant's right hip impairment.

Dr. Reddy found that appellant had 15 percent impairment of her right hip, including 5 percent for 20 degrees of internal rotation, 5 percent for 20 degrees of external rotation, and 5 percent for 20 degrees of abduction. She found no impairment based on 105 degrees of flexion, 20 degrees of extension and 20 degrees of adduction. Dr. Reddy indicated that appellant had moderate-to-severe hip and lower extremity pain but no neurological involvement. There are two problems with Dr. Reddy's impairment rating. She erred in finding no impairment based on 20 degrees of extension. Table 17-9 provides for 10 percent impairment of the hip for 20 degrees of extension. Additionally, Dr. Reddy's finding that appellant had no neurological impairment is not consistent with her finding that appellant had moderate to severe right hip and right lower extremity pain. Table 17-2 allows for the combination of range of motion deficits with a peripheral nerve injury. Due to these deficiencies, Dr. Reddy's report is not sufficient to establish appellant's right hip impairment.

Dr. Mobley stated that appellant had 15 percent impairment of the right lower extremity for loss of range of motion based on Dr. Reddy's report and Table 17-9 at page 537 of the A.M.A., *Guides*. This included five percent for 20 degrees of internal rotation, five percent for 20 degrees of external rotation, and five percent for 20 degrees of abduction. He indicated that there was no impairment for 105 degrees of flexion, 20 degrees of extension and 15 degrees of adduction. However, as noted, Table 17-9 provides for 10 percent impairment for 20 degrees of extension. Additionally, Dr. Mobley did not address the issue of whether appellant had any impairment based on her moderate-to-severe hip and lower extremity pain. For these reasons, Dr. Mobley's report is not sufficient to establish appellant's right hip impairment.

[13] *Id*. at 527, 555.

[14] *See Guiseppe Aversa*, 55 ECAB 164, 167 (2003).

The Board finds that this case must be remanded to the Office for further development of the medical evidence on the issue of appellant's right hip impairment. On remand the Office shall obtain a supplemental report from Dr. Mobley which addresses appellant's impairment due to loss of extension and whether appellant is entitled to an additional award due to peripheral nerve injury for appellant's continued moderate to severe hip and lower extremity pain. After such further development as necessary the Office shall issue a new decision.

CONCLUSION

The Board finds that this case is not in posture for a decision. On remand the Office should further develop the medical evidence on the issue of appellant's work-related right lower extremity impairment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 1, 2008 is set aside and the case is remanded for further action consistent with this decision.

Issued: December 24, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board